Rebalancing Demonstration

California Community Transitions
~ CCT ~

CCT Transition Coordinator Training Webinar

August 2014

http://dhcs.ca.gov/cct

Training Module 1

Overview of (MFP) Money Follows the Person / (CCT) California Community Transitions

Purpose & Intent

- "Rebalancing" Medi-Cal spending by increasing enrollment in Long-Term Services and Supports (LTSS) such as Home and Community-Based Services (HCBS) waivers and programs and State Plan Services (SPS) such as IHSS, decreasing nursing facility (NF) stays.

- Supporting NF residents' choices to move to a community living arrangement.

- Incentive: States receive increased federal dollars for providing HCBS to eligible beneficiaries.

Purpose & Intent (continued)

- To allow states to provide additional "demonstration" and "supplemental" services that extend beyond the scope and duration of existing programs
- To realize approximately $21 million in General Fund savings

CCT Demonstration

- **Funding**
  - Over $82 million
- **Timeline**
  - 1/1/2007 – 09/30/2016 (CMS proposing extension to 2017)
- **Eligible beneficiaries may participate in the demonstration for 365 days.**

Principles

- California Community Transitions is grounded in a partnership between the state, counties, health care facilities, home and community-based service organizations and consumers
- Individuals who reside in nursing facilities and other health facilities have the right to self-determination, access to home and community-based services, independence and choice

CCT Eligibility Requirements

- Persons of **all ages**
- **Continuous** residence in an inpatient nursing facility (freestanding NF or DP/NF, acute or ICF/DD) for a minimum of 90 days, not counting Medicare or short-term rehab days.
- Medi-Cal Eligibility for at least **one** day.
- **Continue to require** the same "level of care" provided in a health care facility.

Target Populations for Transitions

- Elders

Persons with:

- Developmental disability
- Physical disability
- Mental illness

HCBS Waivers/
Programs/Services

IHSS

Nursing Home
Resident

Employment

Community

AT/DME

Health
Care
Services

Community
Services

Independent
Living Centers

Relationship building with SNFs

- Nursing facilities (NF) are aware of the CCT demonstration.
- Each facility is unique and may or may not provide welcome to CCT Transition Coordinators visiting residents without being invited.
- While residents are free to have visitors, it is prudent to do some fact finding and provide general education to each facility Administrator and Director of Nurses.
- Gather information about each facility and keep on file information about location, staff contact numbers and other details on each facility in the area.
- http://communitychoices.info/OC/workgroup-documents/documents/NursingHomeFacilityInformationSheet.doc - Nursing Home Info. Sheet

About SNF Staff

- Facilities have designated staff persons who are responsible for planning orderly discharges.
- Should be part of any MFP transition planning team.
- May not be trained in all the nuances of person-centered planning, the local LTSS service networks, assistive devices, housing options and other necessary components for individuals to make informed decisions with all the available options in mind.
- It is prudent to become familiar with facility resource people. Create relationships!
- Collaboration and Cooperation.

Enrollment

vs.

Participation

Transition to:

- ***Where?***

  Living in the community

  Apartment, House, Publically Subsidized Housing, Assisted Living Facility,

  or Small Group Home

- ***What?***

  Receiving services in the community

  Waivers, Programs and/or State Plan Services

Lead Organization's Role in the Transition Process

- Establish relationship
- Determine inpatient facility length of stay.
- Check Medi-Cal eligibility.
- TC meets with enrollee to gather information on service and care needs for community living.

Process

Steps	Deliverable(s)		State Approval	Outcome	CCT Lead Organization Performance Measures
	Keep On-site	Submit to State			
1. **Outreach and Targeting** • Develop relationships with area SNF and MCHP (not required) • Receive a list of names of people requesting more information about community integration (MDS, Section Q)	○ CCT LO – MCHP contracts ○ MDS Referral Tracking Log	☐ ***Monthly Report*** • *CCT Monthly Data Report* • *CCT Monthly Report Summary* • *CCT Monthly Event/Issue Report* ☐ **Tracking Data Sheet for MDS 3.0 Section Q Referral Encounters**		Recognition and on-going business relationships; sustainable network of service providers	
2. **Information Gathering** • Conduct an initial interview with consumer. • For interested beneficiaries who sign the ***CCT Enrollees'/Participants Rights & Responsibilities/Consent Form & Authorization for Release of Protected Health Info.***, TC will collect records necessary to conduct local-level Clinical Assessment. ***CCT Assessment Tool*** ○ LO's RN completes clinical assessment on beneficiary ***CCT Initial Transition and Care Plan*** ○ developed with the majority of needs, services, and supports identified	• ***Authorization for Release of Protected Health Info*** • ***CCT Enrollees'/Participants' Rights & Responsibilities/Consent Form*** o ***24-7 Back-up Plan*** o ***Independent Housing Disclosure*** o *Copy of the signed Lease Agreement*	☐ ***CCT Assessment Tool*** ☐ ***CCT Initial Transition and Care Plan*** ☐ ***CCT NEI Form (& Facility Face Sheet)*** Assessment & Planning **TAR**	• $908.60 "dollar amount" for TC	1. Beneficiary is enrolled in CCT ☐ ***CCT Assessment Tool, CCT Initial Transition and Care Plan and CCT NEI Form (& Facility Face Sheet)*** 2. submitted to DHCS NE for review 3. LO will receive TC hours for work performed if all documentation is provided, regardless of NEII approval.	1. Ratio between the number of beneficiaries who were referred to CCT, and the # of those individuals who signed the ***CCT Enrollees'/Participants' Rights & Responsibilities/Consent Form*** to enroll in CCT

Process (continued)

Steps	Deliverable(s)		State Approval	Outcome	CCT Lead Organization Performance Measures
	Keep On-site	Submit to State			
3. **DHCS Nurse Evaluator (NE) Review** ☐ Clinical Review of Enrollee's ***CCT Assessment Tool, CCT Initial Transition and Care Plan and CCT NEI Form*** ***(& Facility Face Sheet)*** • (with all necessary supporting documentation)			• 100 hours of TC		1. Ratio between the # of beneficiaries enrolled in CCT, and the # those determined to be transition-able by DHCS NEs 2. Maximum, minimum, and average costs of individuals who do not get approved by DHCS NEs
4. **Implementation** ***CCT Final Transition and Care Plan*** • Work with Enrollee, Legal Representative (if applicable), facility discharge planner, MCHP representative, LO RN, & LO TC to develop a ***CCT Final Transition and Care Plan*** that addresses the individual's unique medical and socio-economic needs in the community • Identify & secure appropriate and available HCBS, housing, in home support worker(s), etc.	• Any additional supporting documentation *(keep on site and provide copy to consumer)*	☐ ***CCT Final Transition and Care Plan***, including: ☐ Home Set-Up **TAR** ☐ Home Modification **TAR** ☐ Vehicle Adaptation **TAR** ☐ Assistive Devices **TAR** ☐ Habilitation **TAR** $11.36 / 15 minutes ($45.44 / hour) ☐ ***Baseline QOL***	• Home Set-up $ based on qualified housing arrangement (3 month lifespan) • Home Modification, up to $7,500 (3 month lifespan) • Vehicle Adaptation, up to $12,000 (9 month lifespan) • Assistive Devices, $7,500 (9 month lifespan) • Habilitation $11.36 / 15 min. ($45.44 / hour)	HCB LTSS identified, secured, & ready to implement safe and sustainable transition	1. Ratio between the # of beneficiaries determined to be transition-able by DHCS NEs, and the # those who actually transition to the community 2. Maximum, minimum, and average costs of transition coordination hours for individuals (approved by DHCS NEs) who do not end up transitioning to the community 3. Required CCT documents are being provided to the beneficiary are easily accessible (physically and cognitively) at home/ place of residence

Process (continued)

Steps	Deliverable(s)		State Approval	Outcome	CCT Lead Organization Performance Measures
	Keep On-site	Submit to State			
3. **Follow-Up** • Collaborate with other service providers to ensure a smooth transition to IHSS Social Worker, MCHP Case Manager, or HCBS Case Manager • Review the ***CCT Final Transition and Care Plan*** with the participant and address any needs &/or concerns • Explain that the CCT project ends on day 365, but that existing services will continue as long as the person remains eligible for HCB Medi-Cal services	• Case Management notes	☐ Signed ***Day of Transition Report Form*** ☐ Follow-Up TC **TAR** ☐ ***Follow-Up QOLs*** x 2 ○ Month 11 ○ Month 24	• # hours of post-transition services (see table next page)	The goal(s) of requiring on-going TC contact with transitioned CCT Participants is to provide: 1. Support/resources necessary to address changes in health status; 2. Address previously unidentified needs that only became apparent after leaving the SNF; and 3. A reduced sense of isolation/abandonment after transition, and/or an increase in a person's quality of life	1. Ratio between the # of participants who drop out of the demonstration (death, return to the SNF, etc.), to the # of participants who remain in the community, and to the total # of people who were transitioned 2. Balance between the cost of transitioning individual, and the amount of money that was saved during the time the individual lived in the community

Process (continued)

Post-transition Follow-up*

PLEASE NOTE

- We envision a NEW modifier added to the existing (G9012) which would be U7 (G9012 U7) to specify that the Lead Organization is able to bill for a fixed "dollar amount" of **$908.60** for pre-TC
- DHCS envisions changing **G9012 – U6: Transitional Case Management (TCM) and S5111: Home care training, family** from (1HR. BILLING) to (Quarter HR. BILLING)

Example: Instead of an LO billing $45.43/hr. they should be able to bill for **$11.36 / 15 minutes for the services specified above.**

Service Code ➡ **Post-transition HCB Services** ⬇	**G9012 – U6: Transitional Case Management (TCM)** Coordinated care fee, risk adjusted maintenance, other specified care management. Services to transition an eligible individual from a health facility to a HCB setting. $11.36 / 15 minutes ($45.44 / hour)	**T2017 – U6: Habilitation, residential, waiver** Services to assist the CCT Participant in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in a participant's natural environment. $11.36 / 15 minutes ($45.44 / hour)	**S5111 – U6: Home care training, family** Family training services provided for the families of individuals served under the waivers. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to maintain the individual's safety at home. **HHAs only**** $11.36 / 15 minutes ($45.44 / hour)	**T1019 – U6: Personal Care Services before IHSS starts** Supportive services to assist an individual to remain at home and includes assistance to independent activities of daily living and adult companionship. $3.62 / 15 minutes ($14.48 / hour)
Informal Support / State Plan Services	<u>Months 1 – 3 after transition</u>: Face-to-face 2X / month <u>Months 4 – 12 after transition</u>: Face-to-face 1X / month Additional care coordination required for re-establishing care, if necessary	As required, (based on medical necessity) within the first 3 months after transition, capped at 50 hours	As necessary	N/A
In-Home Support Services	<u>1st Month after transition</u>: Face-to-face 2X / month <u>Months 4, 8 & 12 (Quarterly) after transition</u>: Face-to-face 1X / month <u>Months 2, 3, 5, 6, 7, 9, 10 & 11 after transition</u>: Phone call 1X / month Additional care coordination required for re-establishing care if necessary	50 hours, post-transition (based on medical necessity)	As necessary	As required, (based on medical necessity) before IHSS starts, **<u>not</u>** to exceed 40 hours per week

Process (continued)

Service Code ➡ / Post-transition HCB Services ⬇	**G9012 – U6: Transitional Case Management (TCM)** Coordinated care fee, risk adjusted maintenance, other specified care management. Services to transition an eligible individual from a health facility to a HCB setting. $11.36 / 15 minutes ($45.44 / hour)	**T2017 – U6: Habilitation, residential, waiver** Services to assist the CCT Participant in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in a participant's natural environment. $11.36 / 15 minutes ($45.44 / hour)	**S5111 – U6: Home care training, family** Family training services provided for the families of individuals served under the waivers. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to maintain the individual's safety at home. **HHAs only**** $11.36 / 15 minutes ($45.44 / hour)	**T1019 – U6: Personal Care Services before IHSS starts** Supportive services to assist an individual to remain at home and includes assistance to independent activities of daily living and adult companionship. $3.62 / 15 minutes ($14.48 / hour)
Waiver Services **NF/AH Waiver, Assisted Living Waiver,** **And other Waiver (AIDS, MSSP, SMHCP)**	Months 1, 4, 8 & 12 (Quarterly) after transition: Face-to-face 1X / month Months 2, 3, 5, 6, 7, 9, 10 & 11 after transition: Phone Call 1X / month	50 hours, post-transition (based on medical necessity)	N/A	N/A

* The hours allocated in this chart are the maximum number allowed for each post-transition service package; if additional hours are required based on individual needs &/or circumstances, submit a request for approval of additional hours with a detailed explanation to the assigned state Nurse Evaluator (NE).

** This service code may only be used by Home Health Agencies to train care takers on how to provide medical treatments and maintenance, and the services must be reviewed and approved by state NEs before any training is provided.

(QOL) Quality of Life Survey

Designed to measure seven domains:

- Living situation
- Choice and control
- Access to personal care services
- Respect/dignity
- Community integration/inclusion
- Overall life satisfaction
- Health Status

(QOL) Quality of Life Survey (continued)

CCT enrollees/participants will be interviewed three times:

- At “Baseline”: After they have agreed to participate in CCT, up to 30 days before discharge, but no later than 10 days after discharge from the facility.
- At “First follow-up”: At 11 months after discharge.
- At “Second follow-up”: At 24 months after discharge.

CCT Forms

New Process	New Form(s)

Outreach
& Targeting
	• **Monthly Report**
	  ○ CCT Monthly Data Report
	  ○ CCT Monthly Report Summary
	  ○ CCT Monthly Event/Issue Report
	• **Tracking Data Sheet for MDS 3.0 Section Q Referral Encounters**

Information
Gathering
(copies of the packet will be included in the Participant's take-home binder)
	• **Enrollment Packet**
	  ○ Authorization for Release of Protected Health Information
	  ○ Notice of Privacy Practices
	  ○ CCT Enrollees'/Participants' Rights and Responsibilities/Consent Form
	• **24/7 Back Up Plan**
	• **CCT Independent Housing Disclosure**
	• **CCT Home Set-up Resource**

DHCS NE II Review	• **CCT Assessment Tool** • **CCT INITIAL Transition and Care Plan** • **CCT New Enrollee Information Form** • **CCT FINAL Transition and Care Plan**
Implementation	• **QOL (English & Spanish)** • **CCT Day of Transition Report Form**
Follow Up	• **Service Discontinuation Report**
Additional Form(s)	• **Notice of Action (NOA)** ○ **Your Hearing Rights** • **Assessment of Participant who Completed MFP/CCT Program**

Reporting

1. State CCT sends *CCT Monthly Event/Issue Report* reminder e-mail to LOs on first (1st) business day of the month
2. LOs submit *CCT Monthly Event/Issue Report* by the 15th of the following month
   - LOs also submit any/all outstanding documentation (e.g., CCT LO Service Discontinuation Report form, etc.)
3. State updates the CCT database with information reported on the *CCT Monthly Event/Issue Report* form (and any other data submitted by LOs)
4. Conference calls are scheduled between the 20th and 30th of each month
5. Project Director speaks with each LO to discuss service performance and trends - Project Director also collects referral data
   - "Next Steps" &/or best practices are discussed at the end of the call
6. If LOs identify discrepancies between state & local data during the call, they gather the supporting documentation and submit a copy of each document attached to a copy of their completed *CCT Monthly Data Report*, so state can update database
7. Data is entered, deleted, or revised, within the CCT database (as necessary) **only** when supporting documentation is provided

Reporting (continued)

- **CCT Monthly Data Report**

Lead Organization (LO) provides a monthly data report to the State by the 15th day of the following month.

- Enrollee Data (Pre-Transition)
- Participant Data (Post-Transition)
- Completion 365-days Participation
- Re-Institutionalization
- Discontinuation

Reporting (continued)

- **CCT Monthly Report Summary**

Lead Organization (LO) provides a monthly reporting form to the State by the 15th day of the following month.

- LO Name
- Month
- Year
- Referrals (DHCS, MDS, Others)
- Enrollees (total # of active enrollees & total # of in-active enrollees)
- Participants (post transition)
- Re-institutionalization (during 365-day demo)
- Notes (additional information pertaining to enrollees/participants)

Reporting (continued)

- **CCT Monthly Event/Issue Report**

Lead Organization (LO) provides a monthly event/issue report to the State by the 15th day of the following month.

- Participant CIN, Name
- Type of Event
- Date of Transition
- Date of Admission
- Date of Discharge
- Brief description of the Event/Issue
- Upon discharge, change in CCT-qualified community residence
- Brief description of Participant's current status

Transition and Care Plan (TCP) Putting the pieces together

Health Care Services
- Plan of Treatment (POT)
- Nursing Care Services
- Nutrition Services
- Allied Health/Other Therapies
- Durable Medical Equipment and Supplies

Supportive Services
- Family/Support Persons
- Personal Attendants
- Emergency Back-up
- Housing
- Transportation

Social Services
- Peer Support/Mentoring
- Recreation/Cultural Connections
- Spiritual Connections

Environmental Services
- Home & Vehicle Modification
- Assistive Technology
- Household Set-up

Education/Training Services
- Independent Living Skills
- Attendant Training/Management
- Emergency Planning
- Caregiver Training

Financial Services
- Medi-Cal Codes
- Money Management
- SSI/SSP payments

Other Services
- Employment Services
- Demonstration Services
- Supplemental Services

Transition and Care Plans (TCPs)

- TC meets with enrollee to gather information on service and care needs for community living.
- Enrollee and TC design two Transition and Care Plans (TCPs) listing enrollee's needs and services designed to meet those needs.
- TC determines if transition to community living is feasible, providing for resident's health and welfare.
- Enrollment information and TCPs are submitted to CCT Project staff.

Transition and Care Plan (TCP)

<u>Initial</u> (I-TCP)

Submitted Pre-Transition with CCT Assessment Tool, New Enrollee Info. (NEI) Form & Facility Face Sheet. Signed by Enrollee & RN.

<u>Final</u> (F-TCP)

Submitted documenting LTSS in place prior to enrollee's transition. Signed by Enrollee, RN and Physician.

CCT Project Clinical Staff evaluates feasibility of transition

- If transition is feasible, resident is enrolled, and LO continues to work with individual.
- If transition is not feasible, a notice of action (NOA) is issued for denial of services.

Health Care Consultation

- TC will discuss enrollee's specific health care needs with CCT Project Nurse to determine for which Medi-Cal waiver services the enrollee is eligible, and may apply.
- Choice of waivers/services is presented to enrollee, who chooses services to meet his/her needs.

Waivers, Programs & State Plan Services

HCBS Waivers

- NF/AH
- MSSP
- ALW
- DD
- AIDS
- PFC
- CCI

Specialty Mental Health Consolidation Program

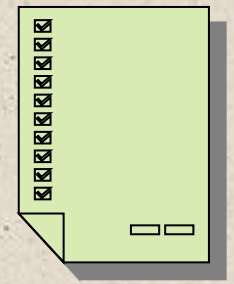
Capitated Care Plan Services

- PACE
- SCAN
- Managed Care

Medi-Cal State Plan Services

- EPSDT
- IHSS

Request for Services



- Application for ***Waiver, Program, and/or State Plan Services*** will be made according to Enrollee's choices.
- Each Waiver/Program/Service has it's own specific application and requirements. TC will assist enrollee to complete paperwork, as needed.
- Notify the CCT Nurse of which application was sent.

Lead Organization's Role (continued)

- Enrollee steers the transition team.
- TC works with Health Care Team and Service agencies to coordinate all needed services (health care, social, and home set-up)
- TC ensures services are set-up and ready to start prior to date of transition.

CCT Services

- Pre-Transition Coordination
- Home Set-Up
- Habilitation
- Family and Informal Caregiver Training
- Personal Care Services before IHSS
- Home Modification
- Vehicle Adaptation
- Assistive Devices
- Transitional Case Management

Lead Organization's Role (continued)

- Obtain enrollment documents and Baseline QoL. The "Baseline" Quality of Life Survey will be conducted up to **30 days** prior to transition, but **no more than 10 days after transition**, per CMS requirement.

Final Check

- Services need to be in place and ready to begin on the day of transition: home set-up, delivery of equipment, financial arrangements, health care, and other services.
- Personal Care Services must start on day of transition (IHSS or WPCS).
- Waiver services may be in process.

!!! TRANSITION DAY arrives !!!

LTSS at Home

- Meet Individual at home the day of transition. Check to insure all needed services are in place and/or available.
- Follow Participant for the 365 days in the community after transition, according to the schedule listed in the lead organization contract.

LTSS at Home (continued)

- A review of the TCP is done at each visit, with changes made to accommodate Participant's ongoing needs.
- At month eleven, review needed services as CCT participation ends soon. All services will continue when CCT participation ends unless beneficiary's health or Medi-Cal status change.